DEPARTMENT OF THE NAVY
NAVAL MEDICAL COMMAND
WASHINGTON, D.C. 20372

IN REPLY REFER TO
NAVMEDCOMINST 6320.2
MEDCOM-35
23 November 1983

NAVMEDCOM INSTRUCTION 6320.2

From: Commmander, Naval Medical Command

Subj: Guidelines for orders not to resuscitate

Ref: (a) BUMEDINST 6320.31B

Encl: (1) Resuscitation (CPR) of Competent Patients
(2) Resuscitation (CPR) of Incompetent Patients

1. Purpose. To promulgate policy and guidelines for writing orders not to resuscitate (DNR or "no code" order).

2. Background. The routine application of cardiopulmonary resuscitation and advanced cardiac life support has given rise to serious questions regarding the appropriateness of attempting resuscitation of every patient who suffers an arrest. Confusion as to criteria for decisions not to resuscitate, identity of decision makers, and a proper decision making process have all further obscured an already difficult problem. This instruction is intended to simplify the problems involved by establishing a clearly delineated decision making process, identifying the appropriate decision makers, and providing criteria for making such decisions. To assure compliance with all appropriate laws and regulations relative to "no code" orders, a system of review has also been identified.

3. Policy. The policy of the Navy Medical Department continues to be the maintenance of life and health in conformity with the highest ethical and medical standards, while preserving the autonomy of its patient and Medical Department personnel.

4. Definitions. As used throughout this instruction, the following definitions have the meanings indicated. The definitions are either consistent with or are derived from the President's Commission for the Study of Ethical Problems in Medicine and, where applicable, local laws and military regulations.

a. Assent. The passive acceptance of a decision made by others.

b. Autonomy. The right of self-determination, i.e., the right of competent persons to form, revise, and pursue a plan of life. In matters of patient care and orders not to resuscitate, it means that the competent patient's own values shall be decisive. It also means that health care providers shall not be required to act in a manner contrary to their own values or professional standards.

c. Cardiopulmonary Resuscitation (CPR). External resuscitative measures used for reviving the heart and the lung.

d. Competence. The ability to make an informed choice. In the case of orders not to resuscitate, it means that the patient understands the relevant risks and alternatives with their attendant consequences. The decision should reflect deliberate choice. Also see "diminished competence" under subparagraph g.

(1) Legal Incompetence. That situation in which an individual is incompetent by operation of law, e.g., a person declared incompetent by judicial decree or a minor.

(2) Factual Incompetence. That situation in which a patient is comatose, unconscious, suffering insane delusions, or is otherwise unable to manage his or her own personal affairs due to mental disability or disease.

e. Consent. Active participation in and agreement with a decision (see reference (a), section A, paragraph 4d for amplification). Also see "informed consent" under paragraph i below.

f. Death Imminent. That condition in which, in the ordinary course of events, death will probably occur within 2 weeks. Note that while a "death imminent" prognosis may be a contributing factor for an order not to resuscitate, absence of such a prognosis does not create a prohibition.

g. Diminished Competence. This condition exists when a patient cannot make decisions that promote his or her well-being in accordance with his or her own previously expressed values and preferences. Diminished competence is often seen as a consequence of pain, therapeutic regimen, or other factors associated with the patient's present medical condition.

h. Family. Those persons sharing a legal or consanguineous (blood) relationship with the patient. This includes the patient's spouse, children, parents, and siblings.

i. Informed Consent. A principle of law embodied within the patient's autonomy or right of self determination. It requires that the patient must be informed of all proposed medical procedures, the material risks of those procedures, alternative courses of action, and the material risks attendant to the alternatives.

j. Mature Minor. Minors 14 years of age or above are generally considered mature minors. Those under the age of 14 may be so considered at the discretion of the medical ethics committee.

k. Medical Ethics Committee. A committee, under the direction of the commanding officer, established to act as a decision making and review authority on all matters relating to orders not to resuscitate. The committee shall be empowered to act immediately when immediate action is warranted or requested.

l. "No Code" or "DNR". Either denotes the clinical circumstances in which cardiopulmonary resuscitation will not be instituted on a patient if cardiac or pulmonary arrest occurs.

m. Optimal Care. Care which assures the comfort, dignity, and physical maintenance of the patient regardless of the existence of orders not to resuscitate.

n. Repairability. The extent to which the illness can be cured, corrected, or otherwise stemmed within existing knowledge and technology.

o. Reversibility. The extent to which known therapeutic measures can effectively reverse the course of the illness.

p. Surrogate. The person who by virtue of family relationship, designation, or court order is recognized as the one to decide for a patient who is incompetent or of diminished competence.

q. Terminally Ill. That condition in which there is no reasonable medical possibility that the patient will avoid death and return to a normal cognitive and sapient state.

5. Procedures for Writing DNR Orders. The following standards must be met when establishing a system to control the issuing of orders not to resuscitate (DNR orders).

a. Only credentialed physicians may write DNR orders.

b. The decision to forego resuscitation efforts is clearly a significant clinical event which must be fully documented on an SF 508, Doctor's Orders. The justification for such an order should be written by the doctor on an SF 509, Progress Notes, using the decision making process described in enclosures (1) or (2), as appropriate. The documentation shall include:

(1) A statement indicating: (a) condition (reversibility or irreversibility), (b) physical status (repairability or irrepairability), (c) mental status (competent, incompetent, or diminished competence), and (d) prognosis (death imminent, nonimminent, or terminally ill).

(2) A summary of patient and family involvement including their attitudes and responses.

(3) An optimal care treatment plan.

c. Orders must be clearly written, signed, dated, and immediately brought to the attention of the ward or unit charge nurse. A verbal or telephone DNR order is not justifiable as sound medical or legal practice.

d. The physician's discussion with the patient or family shall be witnessed by a registered professional nurse or social worker (or higher authority), who will countersign the doctor's Progress Notes.

e. All DNR orders must be reviewed daily by the ward medical officer or higher authority.

f. A mechanism for reporting DNR orders from the ward to the chairman of the medical ethics committee must be established. Ideally, the medical officer writing the order should be held responsible for the initial reporting.

6. Questions or Disagreements. A mechanism shall also be established to afford the patient, any member of the family, or any member of the health care provider team an opportunity to address the medical ethics committee should they question or disagree with the writing of a DNR order or the absence of such an order. Commanding officers shall ensure that patients, families, and staff are aware of this procedure in appropriate instances.

7. Decision Process. Paramount in the decision process is the role of the patient. Underlying guidance in the writing of a DNR order is the fundamental principle that the patient's desires play the dominant role in the decision making process; however, all patients may not be competent at the time a question of resuscitation arises. There are two dimensions to competence: factual and legal.

a. Not Legally Incompetent Nor Factually Incompetent Patients. If a patient who is not legally incompetent nor factually incompetent, as those terms are defined in paragraphs 4d(1) and (2), requests a DNR order, the request will be honored, as outlined in enclosure (1), regardless of the expected benefits of resuscitation. Before making a decision whether or not to write such an order, the following situations will be referred to the medical ethics committee for immediate attention.

(1) Third Party Interests. If reasons are known not to honor a patient's request (e.g., the patient is pregnant, is a sole

or primary provider, etc.), the case shall be referred to the committee. If the committee concludes that there is no legitimate third party interest, then the committee shall consult with the individual asserting the third party interest. If this person then agrees with the committee, the patient's wishes shall be followed; if there is still disagreement, the case may be referred to the courts.

(2) Disagreement With Patient. If there is disagreement with the patient by any health care provider or family member, the case shall be referred to the committee. If the committee concurs with the individual presenting the disagreement, the committee shall recommend that a coercive offer (i.e., that the patient be transferred to another facility) be made or that the case be referred to the courts. If the committee agrees with the patient, the committee will meet with the disagreeing individual. If the individual disagreeing is a health care provider, the health care provider shall comply with the committee's decision or be removed from the case. If the disagreeing individual is a family member, the family may refer the case to the courts.

(3) Military Personnel. Governmental claims of a right to require medical care for the individual member apply only when it can reasonably be expected that the member will return to duty as an active and contributing member of the Armed Forces. Governmental rights should not, therefore, be considered in the case of the terminally ill patient or in those situation wherein treatment, and thus sustained life, would constitute undue suffering. In such cases, the patient shall be treated as any other legally and factually competent patient.

b. Legally Incompetent, Factually Competent Patients

(1) Minors. The decision not to resuscitate any minor, including a mature minor as that term is defined in paragraph 4j, must be made by the parent or a person standing in place of the parent. In making the decision, the parent or substitute must act in the best interest of the minor. If the best interest of the minor becomes an issue, that issue will be referred to the committee for resolution. Additionally, in the case of a mature minor, the minor's assent should also be obtained.

(2) Incompetent Patients. Subsumed under the category of the incompetent patient are those with diminished competence. In all deliberations, the underlying principle is to attempt to determine the decision the patient would have made if he or she was fully competent and informed. This is especially true of those patients whose capacity is diminished as a consequence of pain, therapeutic regimen, or other factors associated with the illness.

(a) Enclosure (2) summarizes the decision alternative first as a function of the provider's assessment of benefit vis a vis the family's views and second as a function of the provider's recommendation and the family's views.

(b) All cases involving incompetence or diminished competence shall be routinely reviewed by, at a minimum, a legal officer and psychologist or psychiatrist to establish competence. If the proposed order is one that in enclosure (2) calls for review or reexamination, then the case must be reviewed by the committee before the order is written.

(c) When the committee concurs with the physician, members of the committee may assist the physician in clarifying the provider's assessment for the family. If the family remains unpersuaded, the provider may make a coercive offer or refer the matter to the courts.

(d) When the committee concurs with the family, the committee shall confer with the physician. If there continues to be disagreement, the physician shall comply with the committee's decision or be removed from the case.

c. Mentally Competent Patients. Mentally competent patients already in a "no code" status, or such a member's next of kin may terminate the "no code" status by stating the desire to a member of the clinical staff, preferably the attending physician. "No code" termination must be immediately documented by a physician in the doctor's Progress Notes and Doctor's Orders and, if the order is written by other than the attending physician, the attending physician shall be notified.

8. Action

a. Commanding officers shall:

(1) Ensure that the provisions of this instruction are immediately brought to the attention of, are understood by, and carried out by all appropriate personnel.

(2) Ensure that local DNR regulations that are apparently inconsistent with this instruction or in need of clarification are immediately brought to the attention of the medical ethics committee.

b. It is also highly recommended that each provider having to deal with orders not to resuscitate become familiar with the bibliography on the subject: Deciding to Forego Life Sustaining

Treatment, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (March 1983).

9. Forms. SF 508, Doctor's Orders (Stock number 7540-01-044-5515 in packs of 100 each and SF 509, Progress Notes (Stock number 7540-00-634-4122)in packs of 100 each may be obtained through GSA stock depots.

W. M. McDERMOTT, JR.

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RESUSCITATION (CPR) OF COMPETENT PATIENTS

Physician's Assessment in Relation to Patient's Preference

Physician's Assessment of Patient	Patient		
	Expressed		
	Favors CPR*	No Preference	Opposes CPR*
CPR would benefit patient	Try CPR	Try CPR	Do not try CPR; review decision**
Benefit of CPR unclear	Try CPR	Try CPR	Do not try CPR
CPR would not benefit patient	Try CPR; review decision	Do not try CPR	Do not try CPR

* Based on an adequate understanding of the relevant information.

** Such a conflict calls for careful reexamination by both patient and physician. If neither the physician's assessment nor the patient's preference changes, then the competent patient's decision should be honored.

RESUSCITATION (CPR) OF INCOMPETENT PATIENTS

Physician's Assessment in Relation to Surrogate's Preference

Physician's Assessment of Patient	Surrogate Expressed		
	Favors CPR*	No Preference	Opposes CPR*
CPR would benefit patient	Try CPR	Try CPR	Try CPR until decision is reviewed
Benefit of CPR unclear	Try CPR	Try CPR	Try CPR until decision is reviewed
CPR would not benefit patient	Try CPR until decision is reviewed	Try CPR until decision is reviewed	Do not try CPR

*Based on an adequate understanding of the relevant information.